State of New Hampshire
Department of Health and Human Services
Medicaid Disability Determination Unit

177a
04/06

Client Name:_____

Member Number:_____

Family Services Specialist:_____

District Office:_____

Date: _____

INTERVIEW OBSERVATIONS

The following comments are the Department representative's visual observations of the applicant, and will not be used in place of the medical information to determine an applicant's medical disability.

Please check the item(s) that the applicant appeared to have difficulty with:

reading	_____	using hands	_____	L ___	R ___
writing	_____	breathing	_____		
answering	_____	seeing	_____		
hearing	_____	walking	_____		
sitting	_____	other	_____		

If any of the above items were checked, please describe the observations: _____

_____

_____

POSSIBLE DISABILITY CONSIDERATIONS

Check any of the following categories which apply to this case:

A. ☐ Amputation of two limbs
B. ☐ Amputation of a leg or hip
C. ☐ Allegation of total deafness
D. ☐ Allegation of total blindness
E. ☐ Allegation of Acquired Immune Deficiency Syndrome (AIDS)
F. ☐ Allegation of diabetes with amputation of a foot
G. ☐ Allegation of cerebral palsy, muscular dystrophy or muscular atrophy and marked difficulty in walking (e.g., use of braces), speaking or coordination of the hands or arms.
H. ☐ Allegation of Down's Syndrome or Intellectual Deficits.
I. ☐ Allegation of a stroke (cerebral vascular accident) more than 3 months in the past and continued marked difficulty in walking or using a hand or arm.
J. ☐ Allegation of bed confinement or immobility without a wheelchair, walker, or crutches, allegedly due to a long-standing condition - exclude recent action or surgery.

Additional comments/observations of Department representative completing this form: _____

_____

_____